

**MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE - PUBLIC HEALTH SERVICES**

DIVISION OF DRUG CONTROL REGISTRATION FOR CONTROLLED DANGEROUS SUBSTANCES (CDS)

4201 Patterson Avenue – 5<sup>th</sup> Fl., Baltimore, Maryland 21215DDC Website: <http://dhmh.maryland.gov/laboratories/drugcont> ■ DDC Email: [MDDC@Maryland.Gov](mailto:MDDC@Maryland.Gov)

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ESTABLISHMENT APPLICATION	3-YEAR CDS REGISTRATION/CERTIFICATION	CDS #:
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<b>FOR OFFICE USE ONLY: APPLICATION AUDIT CONTROL SECTION</b>	<b>Processor Initials:</b> _____	<b>Do Not Write In This Section.</b>
	Date: ____/____/____ Note: _____	

**SEE INSTRUCTIONS ATTACHED.** TYPE ENTRIES IN SECTIONS 1, 2 AND 3 BELOW. SIGN, DATE APPLICATION AND INCLUDE PAYMENT. INCOMPLETE APPLICATIONS WILL BE RETURNED AND DELAYS CDS ISSUANCE. AS NOTED BELOW, UPDATED ESTABLISHMENT QUESTIONNAIRE (EQ) OR COPY OF APPROPRIATE LICENSE (L) REQUIRED. EMAIL ADDRESS REQUIRED FOR RENEWAL NOTIFICATION.\* **KEEP COPY OF APPLICATION FOR YOUR RECORDS.**

**SECTION 1: APPLICATION CLASSIFICATION, TYPE, PAYMENT AND FEE EXEMPT DETAILS****A. CLASSIFICATION - Select only one box ☒. For lawful registration, separate application required for each Establishment Classification.**

Manufacturer <input type="checkbox"/> (L)	Long Term Care/Nursing Home <input type="checkbox"/> (L)	Automatic Dispensing Machines <input type="checkbox"/> (L)
Manufacturer - List 1 Chemical <input type="checkbox"/> (L)	Importer <input type="checkbox"/> (EQ) Importer-List 1 Chemical <input type="checkbox"/> (EQ)	Clinic <input type="checkbox"/> (L)
Distributor <input type="checkbox"/> (L)	Exporter <input type="checkbox"/> (EQ) Exporter-List 1 Chemical <input type="checkbox"/> (EQ)	Drug/Alcohol Programs <input type="checkbox"/> (L)
Distributor - List 1 Chemical <input type="checkbox"/> (L)	Laboratory–Analytical–Schedules II-V <input type="checkbox"/> (EQ)	Law Enforcement Agency K-9 Training–Schedules I-V <input type="checkbox"/> (L)
Methadone Program <input type="checkbox"/> (L)	Laboratory–Analytical–Schedule I <input type="checkbox"/> (EQ)	Animal Control Facility <input type="checkbox"/> (L)
Pharmacy <input type="checkbox"/> (L)	Laboratory–Analytical–Schedules I-V <input type="checkbox"/> (EQ)	Assisted Living Facility <input type="checkbox"/> (L)
Hospital (Human or Animal) <input type="checkbox"/> (L)	Laboratory–List 1 Chemicals <input type="checkbox"/> (EQ)	3PL/Distribute <input type="checkbox"/> (EQ)

B. FEE PAYMENT DETAILS		FOR OFFICE USE ONLY		C. FEE EXEMPT DETAILS FOR GOVERNMENT AGENCIES	
<b>(Fee Payable to DHMH-Drug Control)</b>		App. Receive Date: ____/____/____		<b>CHECK TYPE:</b> <input type="checkbox"/> State <input type="checkbox"/> Local (Agency Unit Code: _____)	
<b>TYPE</b>	<b>FEE</b>	Deposit Date: ____/____/____	Agency/Institution name		
Renewal**	<input type="checkbox"/> \$120	Check/Mo #:	Division/Department		
New	<input type="checkbox"/> \$120	Processor Initials:	Agency/Institution business address		
Address Change Only	<input type="checkbox"/> \$50	<b>Do Not Write In This Section.</b>	Contact Telephone #		
Name Change Only	<input type="checkbox"/> \$50		Print Certifier name		
Duplicate CDS Permit	<input type="checkbox"/> \$30				
Change of Ownership	<input type="checkbox"/> \$144				
Closing	<input type="checkbox"/> \$0				
<b>(Fees are Non-Refundable.)</b> **No additional fee for Name or Address change at time of renewal.			Date: ____/____/____		
				<b>(Signature of Certifier)</b>	

**SECTION 2: APPLICANT DETAILS****SECTION 3: PROFESSIONAL LICENSE DETAILS**

<b>A. Establishment Name/DBA</b>		<b>A. Health Occupational Board, OHCQ, Other License #:</b>	Expiration Date: ____/____/____
		<b>B. Federal DEA #:</b>	Expiration Date: ____/____/____
<b>B. Responsible Person Name (print)</b>	(First)	<b>C. Tax ID Number:</b>	
	(Middle)		
	(Last)		
<b>C. Title</b>		<b>D. Has your federal, State or Health Occupational license ever been denied, suspended, restricted, revoked, reprimanded, or placed on probation?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>D. Business Address</b>		<b>E. Has the responsible person ever been convicted of a violation of law pertaining to CDS?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
City/County/State/Zip		<b>F. Have restrictions been placed on the entity's handling of CDS?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>E. Mailing Address</b>		<b>If yes is the answer to any of the above questions, submit a detailed explanation and copies of pertinent/supporting documentation.</b>	
City/State/Zip		<b>SIGNATURE OF RESPONSIBLE PERSON:</b>	
<b>F. Telephone Nos.</b>	Business:		
	Fax (Required):		
	Alternate or Cell:		
<b>G. Email Address* (Required)</b>		<b>DATE:</b> ____/____/____	<b>Your signature attests to the fact that the information provided is accurate.</b>